SECTION CONTENTS

INTRODUCTION

Purpose

In order to protect public safety and provide adequate services to CONREP patients, program performance standards are required for all contractors. These performance standards are implemented, in part, through core treatment service standards that specify minimum mental health services to be provided.

These services must be specific to the patient and relate directly to his/her individual treatment plan. They provide a basis for evaluating patient adjustment to the community in various settings by assuring appropriate and necessary levels of supervision and treatment.

Increased Services

Public safety and treatment concerns may require that some patients be provided higher levels of service than core service level minimums specify. The program will make this determination and provide the necessary levels within existing contract funding and program limitations.

Reduced Services

Any deviation below the specified core performance standards will require prior written approval from CONREP Operations. The process to obtain a waiver of core service requirements is described in detail later in this chapter. (See **Waiver Process).**

In the absence of an approved waiver, it is presumed that patients will meet one of the existing standards specified, unless provided for by the exceptions below. Note: no waiver is granted for the Annual Case Review.

Service Exceptions

Not Available Status

Patients can be reported as "not available" for core treatment services only under two specific conditions: incarceration or hospitalization for either medical or psychiatric reasons. Services provided to a patient on not available status may be entered into the data system.

INTRODUCTION

AWOL Status

A patient is declared AWOL when the program determines that the patient is absent without leave and therefore not receiving treatment and supervision as ordered by the court.

For those patients on AWOL status, the only services to be entered on the data system are the collateral contacts required for AWOL patients. (For specific AWOL criteria and further discussion, see **Absent Without Leave in Section 1430: SEPARATION PROCESS**).

Monitoring Core Service Compliance

The program will establish a monitoring system to ensure that the minimum Core Services are provided to each patient according to his/her Level in the program and that entries into the data system are accurate and complete.

Procedures for this system should be outlined in each program's Policy and Procedure Manual and should specify the method by which the program will monitor the provision of Core Services to all patients. Procedures should indicate how those services will be entered into the data system, who will do the entry and how the information will be monitored for accuracy. The related responsibilities of the clinicians, Community Program Director and staff should be indicated, as well as the actions to be taken if discrepancies arise between performance and the core standards.

SERVICE SYSTEM

Prior System

Core service standards that provided five minimum levels of intensity based on 'year in program' were established at the inception of the Forensic Conditional Release Program operations in 1986. Subsequent analysis of actual program service performance indicated that actual service intensity varies more by the level of patient functioning rather than by year in program.

Level System

Effective in 1999, CONREP patients were assigned to one of six service levels:

* Levels 1-5: Community Outpatient Treatment; or
* Level 6: Statewide Transitional Residential Program.

Service standards are applied to each patient based on his/her assignment

Patient Movement

The treating program can move patients between levels (including being returned to a higher service level) on the basis of clinical and risk assessments.

Service System Emphasis

This system allows CONREP programs to:

* Increase patient responsibility for progress by reinforcing positive behavior changes;
* Reinforce treatment planning directed toward a goal of discharge; and
* Prepare patients for the community mental health service system upon unconditional release and discharge from CONREP.

CORE SERVICE DEFINITIONS

Forensic Individual Contact

Definition	Forensic Individual Contact is a one-to-one, face-to-face session between a patient and a clinician with a typical duration of 45-60 minutes.
Purposes	The purposes of the individual session are to: * Assess current mental status and level of functioning; * Identify underlying psychological and psychosocial issues that relate to the patient's illness and behavior; * Provide goal-directed therapeutic interventions to facilitate the patient's progress toward the goals and objectives specified in the treatment plan; * Monitor patient's behavior and symptoms for indications of decompensation; * Observe any physical changes and/or possible medication side effects; and * Maintain attention on patient's criminal thought processes and any related behavior.

Group Contact

Definition	A Group Contact is a face-to-face session between a clinician and a group of two or more patients who are usually at a similar level of functioning with a typical duration of 1-2 hours.
Purposes	Group sessions are geared toward one or more of the following purposes: * Assess current level of peer/social interaction; * Expand interpersonal skills by furnishing opportunities for appropriate peer interaction; * Provide group oriented, goal-directed interventions to facilitate coping with mental illness and life situations;

CORE SERVICE DEFINITIONS

Group Contact (cont.)

* Increase patient's cognitive/social skills by
  1. Improving accurate perception of self and others, and
  2. Expanding awareness and ability to communicate with others verbally and nonverbally; and
* Support the development of the patient's capacity to address:
  1. Forensic issues and criminal thoughts and behaviors (related to both self and others), and/or
  2. Other issues related to the development of life skills and adaptive behaviors.

Documentation

Clinical notes of group sessions should indicate assessment of the above capabilities. Surnames of other group members are not to be included.

Home Visits

Definition

A Home Visit is a scheduled or unscheduled visit by a clinician to the home of each patient.

Purposes

The purposes of a home visit are to:

* Determine the patient's current level of functioning both physically and emotionally in the home environment; and
* Assess the patient's living situation by considering the neighborhood environment, the person(s) living with the patient, and the presence or absence of prohibited weapons, unauthorized substances or other contraband.

Observations

Observations made during home visits are to be noted and evaluated in light of the patient's criminal history, mental illness, treatment plan and Terms & Conditions of Outpatient Treatment.

CORE SERVICE DEFINITIONS

Collateral Contact

Definition	A Collateral Contact is a face-to-face (or occasional extensive telephone) discussion with persons who play a significant role in the patient's life and may be a family member, friend, roommate, facility manager, employer, residential facility staff and others identified by the patient. Routine professional consultations with other clinicians are not collateral contacts.
Identification of Contacts	The patient and primary CONREP clinician should identify individuals who can reliably provide feedback about the patient's level of functioning and any possible warning signs. Contacts should be reviewed at least annually to ensure their continued appropriateness. New contacts should be added as the patient enters new situations in which collateral information is available (e.g. new job or residence).
Purposes	The purposes of this contact are to: * Gain an understanding of the patient in relation to significant others; * Obtain relevant information regarding the patient's present level of functioning; * Help persons who are significant in the patient's life to understand and be supportive of the patient's treatment goals/objectives; * Detect signs of decompensation, lapses into criminal behavior or substance abuse; and * Assess compliance with the Terms & Conditions of Outpatient Treatment.
Documentation	A list of a patient's collateral contacts should be maintained in a centralized location in the patient record and include the name of the contact, relationship, address and phone number, the dates on which the contact was added to the list and removed from the list (if applicable), and the date the list was reviewed.

CORE SERVICE DEFINITIONS

Collateral Contact (cont.)

During AWOL Status	There must be at least one collateral contact after a patient has been declared AWOL and must be conducted by the end of the month following the declaration of AWOL (see **Absent Without Leave, Section 1430: SEPARATION PROCESS)**.

Substance Abuse Screening

Definition	Substance Abuse Screening consists of obtaining urine samples from each patient. These should be collected at random, unscheduled times and submitted for analysis to the CONREP statewide contract laboratory.
Purpose	The purpose of these screenings is to confirm the presence or absence of a specified panel of unauthorized substances in order to accurately assess the patient's substance abuse behavior. (See **Section 1460: SUBSTANCE ABUSE MANAGEMENT)**.

Annual Case Review (Assessment)

Definition	The program staff conducting an Annual Case Review meets the assessment core service standard requirement. The Annual Case Review is typically conducted in an interdisciplinary staff meeting during which a patient's clinical status is reviewed prior to making yearly dispositional recommendations to the court.
Purpose	The purpose of an Annual Case Review is to update treatment goals and objectives through consideration of all relevant clinical data. A summary of the discussion should be entered in the patient's record and the results of this review presented in the annual report to the court. For detailed requirements relating to conducting the Annual Case Review and meeting the core service assessment standard, see **Annual Case**

Review, SECTION 1610: ASSESSMENT SERVICES.

COMMUNITY OUTPATIENT TREATMENT

Description

Community Outpatient Treatment is the successor to the CONREP Minimum Core Services that were formerly determined by year in the program and recasts the minimum core service standards into five levels. The first five levels apply to patients in the CONREP community outpatient treatment program. The sixth level applies only to patients in one of the Statewide Transitional Residential Programs (STRP). (See below.)

Assignment of Level

The Community Outpatient Treatment Core Service Level is determined on the basis of the patient's placement (community outpatient treatment program or STRP) and on the program's assessment of the patient's performance and risk. The Community Program Director assigns the appropriate level by entering the level in the data system.

Minimum Core Standards

Each Community Outpatient Treatment Core Service Level (see definitions below) has specific minimum core service standards that must be met. These standards are delineated in the **Minimum Core Standards by Service Level Chart** (see below).

Program Performance

Program performance is measured against the minimum core service standards for that level until such time as it is changed or the patient is discharged.

COMMUNITY OUTPATIENT TREATMENT

Community Outpatient Treatment Levels

Intensive Level

This level is appropriate for patients who meet one or more of the following descriptions. The patient has:

* Recently been admitted to community treatment;
* Transferred from a Statewide Transitional Residential Program;
* Returned from a temporary hospitalization or Forensic IMD admission lasting more than 30 days;
* Demonstrated problems adjusting to community life, medications or program expectations; and/or
* Been assessed to be at the highest acceptable level of risk.

Patients assigned to this level of service require ongoing assessment based on the nature of their offenses and risk factors, as determined from their criminal and mental health histories and the precursors to their offenses. Service duration is typically 6 to 12 months, but may be indefinite based on an ongoing clinical assessment of the patient.

Intermediate Level

This level is appropriate for patients who:

* Are cooperative with the program but still pose a relatively higher risk; and/or
* Have significant unresolved issues affecting their adjustment to stable community care.

Patients at this level require frequent program interventions, close supervision and management. Service duration is typically two to four years, but may be indefinite based on an ongoing clinical assessment of the patient.

This level is appropriate for moderate risk patients with intractable symptoms who require ongoing psychosocial and medication support. Patients assigned to this level are not considered ready for discharge and need ongoing program services for an indefinite period of time.

COMMUNITY OUTPATIENT TREATMENT

Community Outpatient Treatment Levels (cont.)

Supportive Level	The number of Forensic Individual and Group Contacts to be provided for patients on this level must be determined on the basis of a clinical assessment by the treatment team and specified in the patient's treatment plan. That portion of the treatment plan in which Forensic Individual Contacts are specified is referred to as the *Individualized Case Management Plan* (see below). That portion of the treatment plan in which Group Contacts are specified is referred to as the *Individualized Socialization/Vocational Rehabilitation Plan* (see below).
Transitional Level	This level is appropriate for patients who have progressed through other Community Outpatient Treatment levels and are being considered for progression to Aftercare Level or discharge. This level allows for the development of a community aftercare plan and an individualized program of services to meet the needs of the lower risk patient. Service duration is typically one to two years, but may be indefinite based on an ongoing clinical assessment of the patient. As determined by a clinical assessment, the number of Group Contacts must be specified in the patient's Individual Plan, which becomes part of the patient's overall treatment plan.
Aftercare Level	This level is appropriate for patients who might be unconditionally released in the near future. It permits for a community aftercare plan to be implemented on a trial basis (typically for up to one year). It is intended to prepare patients for the final aspects of discharge planning and to assist them in fine-tuning community integration and independent living abilities. The community aftercare should consist of services provided by community agencies, private practitioners or other non-CONREP community support systems to the extent that these services are available to the patient.

COMMUNITY OUTPATIENT TREATMENT

Community Outpatient Treatment Levels (cont.)

Aftercare Level (cont.)	The patient's community aftercare plan is monitored by the program in order to assess his/her readiness, motivation and ability to adhere to this plan once the structure of CONREP has been removed. Minimum core service standards are an Individual Contact, Home Visit, and Collateral Contact once per quarter, as well as an Annual Case Review. The Home Visit can be conducted in conjunction with the Individual Contact. If the patient has a history of substance use, a Substance Abuse Screening should also be conducted once per quarter. Minimum core service standards at this level are not subject to waiver requests as they are considered to constitute the minimum level possible.
Supportive Level: Individual Contacts	The requirement for Forensic Individual Contact calls for an "Individualized Case Management Plan." Programs must specify in the treatment plan the number of forensic individual contacts (15/80) to be provided each month.
Supportive & Transitional Levels: Group Contacts	Both the Supportive and Transitional Level requirement for Group Contact call for an Individual Plan. For patients on either level of service, programs must specify in the treatment plan the number of services to be provided each month in any of the service functions: 10/30, 10/40, 10/80, 10/90 or 15/50.

Statewide Transitional Residential Program

Program Description	A Statewide Transitional Residential Program (STRP) is a licensed non-medical Community Care Facility that provides a highly structured residential program to assist patients' transition from the state hospital to the community. In other cases, if patients experience difficulty adjusting or coping in the community, they may be placed in a STRP in lieu of rehospitalization. Service duration is typically three to four months and should not exceed 120 days.

COMMUNITY OUTPATIENT TREATMENT

Community Outpatient Treatment Levels (cont.)

Service Standards	The unique core service standards and discrete service function codes reflect the behavioral and social rehabilitation model employed by these programs. This service model emphasizes group psycho-educational activities in the treatment process. Core treatment services for individual contacts, group contacts, substance abuse screenings, and a monthly collateral contact are provided by the residential treatment staff. Home visits, one collateral visit per month and Annual Case Reviews are provided and reported by the program of commitment.
Residential Individual Contacts [15/85]	A Residential Individual Contact (15/85) is the same as a Forensic Individual Contact (see **Core Service Definitions** earlier in this section) and should be provided twice per month. In addition to this minimum level of service, other individual contacts may be conducted in combination with group contacts, up to a total of 10 contacts per month.
Residential Group Activity [15/55]	In addition to group psychotherapy, Residential Group Activity services (15/55) include psycho-educational groups, such as substance abuse, anger management, medication awareness and skills of daily living. Excess Residential Individual Contacts (beyond the minimum requirement of 2 per month) may be counted toward the Residential Group Activity standard of 10 contacts per month.
Residential Collateral Contact [15/15]	Collateral services (15/15) are provided by both the program of commitment and the STRP staff once a month. They can be provided at the same time and may be billed by each program. The standard is met when a total of two collateral contacts (one 15/15 from the Residential program and a 15/10 from the program of commitment) are entered into the data system.

COMMUNITY OUTPATIENT TREATMENT

Community Outpatient Treatment Levels (cont.)

Home Visit	The program of commitment provides home visits which involves a face to face meeting with the patient and the STRP staff. As a result, there is no need to assign a unique service function code for services to patients in an STRP. Home visits should occur at least quarterly and are reported by the program of commitment.
Substance Abuse Screening	Urine tests for substance abuse should occur on a weekly basis and there is no need to assign a unique service function code for such services.
Annual Case Review	The program of commitment conducts the Annual Case Review should that fall due during the patient's stay at the STRP.

COMMUNITY OUTPATIENT TREATMENT

MINIMUM CORE STANDARDS BY SERVICE LEVEL

SERVICE FUNCTION TYPE	LEVELS					
	Intensive	Inter-mediate	Supportive	Transi-tional	Aftercare	Statewide Transitional Residential Programs
Forensic Individual Contact	Weekly (4 per month)	Three Times per Month	# Individualized Case Management Plan	Monthly (1 per Month)	Quarterly (1 every 3 months)	2 per Month
Group Contact	Weekly		# Individualized Socialization/ Vocational Rehabilitation Plan		None	* 10 per Month in Combination
Home Visits	Twice per Month	Monthly		Quarterly	Quarterly	Quarterly
Collateral Contact	Twice per Month	Every Other Month (6 per Year)			Quarterly (can be done in conjunct-ion with Home Visit)	Twice per Month
Substance Abuse Screening	Weekly	Twice per Month		Quarterly	If history, then quarterly	Weekly
Annual Case Review (Assessment)	YEARLY (One per Year)					Yearly
Additional services may be provided as determined by the patient's treatment plan.						

**These service plans must specify the number of Individual or Group Contacts (See 1340).**

***** **In addition to 2 per month baseline for individual contacts, other individual and group contacts may be combined for a total of 10 per month (See 1340).**

WAIVER OF CORE SERVICE STANDARDS

Purpose

Provision of services below the core treatment service standards requires a prior approved waiver. The purpose of the waiver is to allow for deviation from the core service standards in those instances in which clinical or medical considerations and/or logistical difficulties render provision of specified core services inappropriate or impractical. Waivers can be either patient- or program-specific.

Waiver requests may include substitution of an alternative service, lowering of service frequency or deletion of a service requirement. Waiver requests may not include minimum core services required at the Aftercare Level of treatment.

Time Limit

Waivers are granted for a specific period of time not to exceed 12 months. If approved, the waiver starts no earlier than the month in which received by CONREP Operations. A new waiver will be required if the program wishes to continue beyond the 12 month period. Waivers start at the beginning of a new month and finish at the end of a month.

Patient Specific Waiver

CONREP Operations will not issue any "blanket waivers" for groups of patients. Requests to vary the service level must be sought for each patient and for identified modes of service. Multiple service waivers or substitutions requested for one patient should be submitted on one Waiver Form so that reviewing staff can gain an overview of the overall treatment and supervision level for the patient.

WAIVER OF CORE SERVICE STANDARDS

Alternative Considerations

A waiver will not be granted for an entire mode of service unless a thorough discussion of alternative means of achieving the intent of the standard is presented. For example, the group requirement cannot be waived solely because an appropriate psychotherapy group is unavailable.

A discussion of alternative means of meeting the group requirement must be included (e.g. Head Injury Group or Socialization Center). Creative alternatives are encouraged and substitutions explored (e.g. increased individual sessions) when requesting a waiver of a specific standard.

Program Specific Waivers

Description

Certain types of treatment programs may be considered for a Program Specific Waiver and may include designated residential treatment facilities for substance abuse treatment. As these programs may not allow a patient to leave the facility over a period of time, the patient cannot attend the CONREP Group Therapy.

Submission of Program Specific Waiver Request

The program should submit a written explanation of the program, the reason for the requested waiver, and the type of Program Specific Waiver that it seeks to obtain.

If the Program Specific Waiver is approved, then the program need only submit the Waiver Form MH 1712 with an original and 3 copies on a specific patient without the accompanying background information. This form would need to be filled out completely including the "Rationale for Waiver" but excluding the "Alternatives Considered" area on the form.

WAIVER OF CORE SERVICE STANDARDS

Waiver Submission (Form MH 1712)

Form MH 1712, Request for Waiver of Core Service Standards, is to be completed by the program, specifically by the person having direct treatment and supervision responsibility, reviewed by a supervisor and countersigned by the Community Program Director.

An original and 3 copies of the form and required documentation are submitted to CONREP Operations for review and approval.

Committee Review

The completed waiver submission package (including all attachments) will be reviewed by the Waiver Committee which is composed of both DMH and CONREP program staff. Additional information may be requested.

This committee will make a recommendation on each waiver submitted to CONREP Operations, which has the final decision and will record that decision on the MH 1712 Form.

Distribution of Approved Waiver

CONREP Operations will retain one copy, return the signed original form to the submitting program, forward a copy internally for input into the data system and a third copy will go to CONREP Operations' staff who chairs the Waiver Committee meeting.

Change or Cancellation

To change or cancel an existing waiver, a new waiver request, indicating the new frequency for the core service, must be submitted. The new waiver will supersede any old waiver from the time of the new start date. Any elements that are to remain the same must be included in the new waiver submission.

SERVICE DELIVERY CONDITIONS

Core Service Provider

The CONREP program or subcontractors must provide Core Services pursuant to the Conditional Release Program contract unless exceptions have been approved by CONREP Operations.

Discrete Services

Each CONREP core service is a discrete mental health service. Only one mental health service can be provided and billed at a time. Different mental health services may not be provided concurrently but may, under some circumstances, be provided sequentially.

For instance, if collateral or individual contacts are conducted while making a home visit, they must be done sequentially and documented separately. Additional time must be allocated to ensure provision of separate complete services. Substance abuse screenings may be conducted while making a home visit.

Clinical Notes

Following the provision of any mental health service, appropriate individualized clinical notes are to be recorded in the patient's record. These notes should indicate the services provided as well as the patient's response/interaction. Over time, they should reflect that the criminal history, mental illness and treatment plan are addressed during service contacts (see **Forensic Focus** later in this section.).

FORENSIC TREATMENT COMPONENTS

Overview

The primary emphasis of forensic treatment is relapse prevention. Two elements of relapse prevention that are particularly important in working with forensic patients are to help them:

* Recognize patterns leading to their offenses and
* Develop alternative behaviors that do not lead to offense.

Documentation

The treatment plan, interdisciplinary notes, Annual Case review, assessment and court reports contained in the patient's record should all reflect the forensic treatment components, as described in this section. Clinicians must document specific problem behaviors, warning signs and/or any pertinent observations, as well as all actions taken in response to these.

Forensic Focus

Mental Disorder and Criminal Behavior

CONREP therapeutic activity should be based on an awareness of the relationship between the patient's mental disorder and criminal behavior.

Focus of Treatment

The focus of treatment should be the controlling offense, mental health/criminal history and warning signs and high-risk elements that staff and/or patient identified as leading to relapse.

Treatment should be organized around the identification of behavioral patterns, especially those exhibited prior to and during the offense. Patient recognition of these patterns and the development of adaptive coping strategies to deal with them also need to be included as important aspects of the patient's treatment.

FORENSIC TREATMENT COMPONENTS

Forensic Focus (cont.)

Other Program Functions	This forensic focus should be evident in evaluations, assessments, and case conferences treatment plans, interventions, as well as in the documentation of services provided. It should especially be reflected in reports to the responsible authority (court, Board of Prison Terms or parole officer). These reports should reflect the patient's progress toward developing and maintaining a relapse prevention plan relative to the behavior problems identified. The Annual Case Review assessment, as well as all decision making (such as discharge planning, continuance in the program, changes in living situation or other major life decisions), should be guided by this forensic focus.

Treatment Planning

Individual Treatment Plan	The Individual Treatment Plan consists of treatment goals and objectives that include a focus upon: * The patient's offense; * Offense-related situations and behavior; * Development of adaptive coping behaviors; * Criminal thought processes; * Precursors and risk factors; * Warning signs; * Diagnosis; * Medication management; and * Commitment type. A critical element of treatment planning is assessment of risk and the development of an Individual Risk Profile (MH 7025). The forensic focus is incorporated into the development of patient treatment goals and objectives. These goals and objectives should be consistently addressed during provision of core services so that the patient can learn to develop adaptive behaviors leading toward a relapse-free lifestyle.

Treatment Planning (cont.)

Treatment Goals	Treatment goals, or outcomes, are long range, major changes that are expected to be achieved over time in treatment.
Treatment Objectives	Treatment objectives are those specific behaviors that the patient must achieve or eliminate as a step toward meeting a goal. Objectives should be clearly delineated, behaviorally specific and quantifiable. Objectives should consist of specific behaviors that are operationally defined, observable, and measurable by anyone observing the behavior.
Interventions and Treatment Modalities	Treatment plans should also identify the intervention methods and treatment modalities that will be used to help the patient achieve his/her goals. Interventions are the types of methods used in treatment to bring about the desired changes. Behavioral, cognitive and insight-oriented approaches are some examples of intervention methods. Treatment modalities refer to the format in which the therapeutic contact takes place. Typical modalities are individual, group, family, and day treatment or socialization services.
Outcome Criteria	Specific criteria should be established which indicate at which point the goal is considered to have been achieved. Criteria are typically stated in terms of the elimination or the acquisition of particular behaviors. In addition, the patient must maintain the new behaviors for a period of time that is sufficient to demonstrate that the change will continue after treatment has ended.

FORENSIC TREATMENT COMPONENTS

Treatment Planning (cont.)

Adaptive Behavior Alternatives	In order to achieve the desired outcome, specific behaviors may need to be taught in place of undesirable, inappropriate behaviors. Many patients have skill deficits that will need to be addressed so that adaptive behavior alternatives can be learned. The types of skills necessary to learn these alternative behaviors include: * Coping skills; * Interpersonal skills; * Cognitive processing skills; * Perceptual skills; * Communication skills; and * Problem solving skills.
Updates	Treatment plans should be updated at least annually and, as needed, in response to case conferences, clinical staffing, special incident analyses and other forms of objective assessment.
Filing	The Individual Treatment Plan shall be retained in a uniform place in each patient record.
Risk Factors	It is essential that CONREP clinicians are aware of probable risk factors for each patient regarding decompensation, reoffense and/or violence. Some common risk factors are: * History of criminal activity; * Youthful age (under 30); * History of violence; * Chemical abuse; * Command hallucinations; * Other auditory hallucinations (particularly with self-reference); * Paranoia; * History of animal torture as a child; * Isolation, lack of social support system; and * Excessive preoccupation with military or sexual themes.

FORENSIC TREATMENT COMPONENTS

Individual Risk Profile (MH 7025)

Purpose of Form MH 7025	To improve the identification of a patient's risk factors and to include them as the focus of treatment, the Individual Risk Profile (MH 7025) became operational July 2001, replacing the Precursor Profile Summary (MH 7014).
Completion Timelines	The MH 7025 Form shall be completed on all patients at the following times: * At the time of the Annual Case Review for current patients; * Upon the referral of an inpatient for COT or within 30 days of admission to CONREP; * Upon consideration of discharge (this includes PC 2968 request for MDO Remission Certification); and * At the discretion of the treatment team, whenever significant changes merit a reassessment of risk factors.
Factors Related to Offense	Completion of a MH 7025 necessitates obtaining detailed information about the instant offense and the circumstances that led up to it. Understanding the circumstances leading up to and surrounding the instant offense entails identification of individual high-risk behaviors and situations. Obtaining this information will involve a thorough review of various documents (e.g. police reports, alienist reports, reports completed in the early stages of inpatient treatment and/or incarceration). It will involve repeated and detailed discussions of the instant offense with the patient. This information should be summarized on the MH 7025 and the form retained in the patient record in the same section as the treatment plan.

FORENSIC TREATMENT COMPONENTS

Individual Risk Profile (cont)

Utilization of 'Level of Risk' and 'Factors Related to Offense' Information	Information indicated for 'Level of Risk' (see discussion of HCR-20) and 'Factors Related to Offense' are utilized as a basis for formulating: * Specific decisions about the patient; * Development of the patient's treatment plan; and * Information provided about the patient in quarterly and annual reports to the court/ BPT. **(**See **Section 1420: Reports & Annual Review Process.)**

FORENSIC TREATMENT COMPONENTS

HCR-20

Administration and Training	Developing the Individual Risk Profile necessitates assessing each patient's violence risk level using the HCR-20. It is recommended that each patient's primary therapist complete this assessment tool. Before staff can administer, score, and utilize the HCR-20, they must complete training authorized by CONREP Operations. Training is obtained by attending a training session or viewing a videotape of a training session which is available through Forensic Services. Program staff must also complete five practice scorings under the supervision of the Forensic Assessment Project's consultant prior to using the HCR-20 independently with patients.
HCR-20 Item H7 (*Psychopathy)*	The scoring of this particular item requires administration of the Hare Psychopathy Checklist – Screening Version (PCL-SV) or Revised (PCL-R). If a PCL-SV or PCL-R has already been administered by a qualified examiner, there is no need to also administer the PCL-SV. However, if a PCL-R has not been administered, appropriately trained CONREP staff should administer a PCL-SV. If the patient's score on the PCL-SV falls above the Low range, the patient must then be referred to the California Forensic Assessment Program (CFAP) for administration of the PCL-R. Qualifications for the administration and scoring of the PCL-R are enumerated in the PCL-R manual (pages 5-9) and must be strictly followed. If no program staff are specifically trained in the use of the PCL-R, a request for administration should be forwarded to CFAP. CFAP consultant will first review their files to determine if this instrument was administered. If so, information necessary for HCR-20 Item H7 will be provided. If not, arrangements will be made for administration of the PCL-R.

FORENSIC TREATMENT COMPONENTS

HCR-20

HCR-20 Item H7 (*Psychopathy)* (cont.)	Before program staff can administer and score the PCL-SV, they must complete formal training that is provided or authorized by CONREP Operations. Authorization for training should be received prior to staff attending the training.
Completed Coding Sheets	Once scored, HCR-20 coding sheets are to be filed in a separate file with other psychological raw data and not in the patient record. Completed HCR-20 coding sheets should not be filed in the patient record.
Results as 'Level of Risk' on MH 7025	Results of the HCR-20 are to be presented in terms of Level of Risk rather than raw scores. The assessed Level of Risk should be recorded on the Individual Risk Profile in the space provided.

PROBLEM BEHAVIORS

Description

During treatment, patients may present a variety of problem behaviors. The following discussion is presented in order to promote statewide conformity in program response to some of the more significant of these behaviors.

Violations of Terms and Conditions of Outpatient Treatment

Each patient signs **Terms and Conditions of Release to Outpatient Treatment [MH 7018]** upon community outpatient admission (See **Evaluation Procedures, SECTION 1410: ADMISSION PROCESS**). Failure to comply with one or more provisions is considered a violation of the Terms and Conditions. The following behaviors are examples of violations which may lead to hospitalization or revocation:

* Consistent pattern of non-compliance or uncooperative behavior:
  1. Repeated missed appointments,
  2. Late to appointments,
  3. Non-participation in sessions, and/or
  4. Failure to take prescribed medications;
* Signs of the presence of weapons, contraband or prohibited substances;
* Refusal to give a substance abuse screening sample;
* Failure to permit home visits; and/or
* Denial or refusal to name any collaterals.

Threats

Urgent consultation and staffing conference are recommended; prompt hospitalization may be indicated, with notification of intended victims, collaterals, and other staff, as appropriate.

Change in Mental Status

Any significant change in the patient's mental status requires careful evaluation and may require an immediate staffing. Emergency hospitalization or revocation may be indicated.

Medication Side Effects

Possible medication side effects require staff awareness and attention to physical and mental symptoms. The presence of any such symptoms requires accurate documentation and prompt notification by the program to the psychiatrist.